ANALYTICAL AND BIBLIOGRAPHICAL NOTICES.

ART. XXVI.—*Medico-Chirurgical Transactions.* Published by the Royal Medical and Chirurgical Society of London. Volume the Fifty-eighth. 8vo. pp. lxviii., 393. London: Longmans, Green, Reader, and Dyer, 1875.

IN accordance with custom, we purpose offering to our readers some account of the various papers embraced in the present volume of this excellent series, considering first those which are specially addressed to *surgical* practitioners, and subsequently those which are more distinctively of *medical* interest.

The first paper describes a remarkable *Case of a Foreign Body impacted for twenty months in the Female Pelvis; Recovery after its Removal;* and is contributed by RICHARD BARWELL, F.R.C.S., Surgeon to Charing Cross Hospital. The patient was a young, unmarried lady, whom Mr. Barwell saw in consultation with her ordinary medical adviser; the latter had been called in fifteen months previously on account of severe pain in the left hip and thigh, which the patient ascribed to sciatica, but which her physician regarded as due to some deep-seated cause of irritation, the nature of which he could not discover. Eleven months afterwards he was again consulted, and found the patient suffering from an abscess over the hip; and now, by questioning, ascertained that some months before his first visit she had had an abortion produced by the introduction of an instrument (supposed to be an elastic catheter), which was left in position, and which a few hours later disappeared within her body. Mr. Barwell opened the abscess, evacuating a pint of very offensive pus, mixed with intestinal gas, and a few days later, by careful exploration by both rectum and vagina, succeeded in discovering a foreign body, which he could just touch through an opening in the bowel, and which, with some difficulty, he withdrew through the anus. The foreign body proved, as had been suspected, to be an elastic catheter, which had lain for twenty months in the areolar tissue, between the uterus and rectum. The abscess healed rapidly after the operation, and in less than two months the patient was quite restored to health. Mr. Barwell supposes that the catheter had been introduced, armed with its stilette, and had been pushed directly backwards through the posterior uterine wall into the adjacent connective tissue.

The next paper is entitled *Cases of Syphilitic Reinfection; with Remarks,* and is from the pen of a gentleman whose recent death has been a source of regret to the medical profession in other countries as well as in his own, Mr. GEORGE GREEN GASCOYEN, F.R.C.S., Surgeon to the Dock Hospital, Assistant Surgeon to St. Mary's Hospital, etc. A report of Mr. Gascoyen's communication has already appeared in the *Monthly Abstract of Medical Science* for February, 1875 (p. 67), which is seen by most of our readers, and we shall not, therefore, dwell upon it further than to say that several of the author's cases seem to us quite inconclusive. That a second attack of syphilis may occur we are, of course, prepared to admit; but that such an occurrence is as common as supposed by Mr. Gascoyen, we cannot believe. We have no doubt that some at least of his examples of supposed re-infection were really nothing but fresh outbreaks of old constitutional disease, accompanied by that most deceptive lesion to which Fournier has particularly called attention, the "*pseudo-chancre induré.*"

We shall next turn to a paper on *Urinary Crystals and Calculi; being Observations on some of the circumstances determining the Forms of Crystalline Deposits in Urine, and on some of the conditions under which Renal and Vesical Calculi are produced;* by WILLIAM MILLER ORD, M.B. Lond., F.R.C.P., Senior Assistant Physician and Lecturer on Physiology at St. Thomas's Hospital. In a paper contributed to the first volume of the new *St. Thomas's Hospital Reports* (see No. of this Journal for April, 1871, p. 523), Dr. Ord described some experiments relating to the forms assumed by uric acid under different circumstances, and showed that those forms varied according to the character of the fluid from solution in which the acid was thrown down. In the present communication he details the results of further investigations not only as to uric acid, but as to urate of ammonia, oxalate of lime, and triple phosphate also. We have not space to go into a full examination of Dr. Ord's paper, which seems to us one of much value, but must content ourselves with referring to a few points of practical importance. After showing that the actively changing colloids which enter into the matter of purulent mucus exert a strong converting and cementing influence on uric acid, and referring to the views advanced by Dr. Vandyke Carter in his work on the *Microscopic Structure and Mode of Formation of Urinary Calculi* (noticed in the number of this Journal for April, 1874, page 491), Dr. Ord says:—

> "Two-thirds of all urinary calculi are in bulk composed of or start from concretions of uric acid. . . . . To make calculi of uric acid without colloids would be as hopeless a task as making ropes of sea sand. Therefore, if the causes of the varying prevalence of calculous disease in different communities and regions are to be fully and usefully examined, such subjects as constitutional proneness or indisposition to vesical catarrh, habits of life, diet and regimen, or local conditions of soil, water, and climate which can hinder or promote the secretion of mucus, or the occurrence of irritation in the urinary tract, must be very carefully treated. And if such observations be applied to practice, we may hope to find that the prevention of stone becomes partly possible through the prevention of the local conditions which constitute the soil in which it is sown and grows."

And with regard to the formation of oxalate of lime concretions, the author says:—

> "To mould oxalate of lime into calculi would seem to require denser colloids than are usually present in vesical urine, and it is probable that the beginnings of oxalic calculi take place in the recesses of the kidney among less diluted colloids. Certainly, in my own experience I have found the small calculi passed with so much pain from the kidneys much more frequently composed of oxalate of lime than are vesical and urethral calculi."

Dr. Ord's paper is accompanied with two lithographic plates, showing the forms assumed by urinary deposits under different circumstances.

The next paper is a very long one, occupying, indeed, one-fourth of the whole volume; it is entitled *A Case of Pulsating Tumour of the Left Orbit, consequent upon a Fracture of the Base of the Skull, cured by Ligature of the Left Common Carotid Artery subsequently to Injection of Perchloride of Iron after Digital Compression and other means of treatment had failed; with Remarks and an Appendix containing a Chronological Resumé of Recorded Cases of Intra-orbital Aneurism;* by WALTER RIVINGTON, M.S. Lond., F.R.C.S. Eng., Surgeon to the London Hospital. This is a paper of much excellence, and one which reflects great credit upon its author's industry and powers of research. It constitutes the most valuable single contribution to the literature of its subject with which we are acquainted. Before entering upon an account of his own case, Mr. Rivington gives a sketch of the views entertained by previous writers with regard to the affection generally known as "intra-orbital aneurism," a name which, as he justly remarks, is really appropriate to but a very small number of those cases to which it is applied. Mr. Rivington's own patient was a man twenty-four years of age, in whom the symptoms of the disease were first manifested between six and seven weeks after the reception of an injury by which the patient sustained a fracture of the skull. Compression, both digital and instrumental, of the carotid artery; digital compression of *both* carotids; and direct compression of the pulsating tumour, were tried at different times during the following year, but with no benefit to the patient. The case being regarded as one of arterio-venous aneurism, a communication probably existing between the carotid artery and cavernous sinus, and it being feared, from the negative results of compression, that ligation of the carotid would produce but temporary improvement, it was determined to inject a solution of the perchloride of iron, in hope of obtaining obliteration of the dilated ophthalmic vein. Accordingly, five minims of a neutral, watery solution, of the strength of 28 per cent., were injected into the pulsating swelling below the orbital arch. Quite severe symptoms, both local and constitutional, followed the injection, and four days later it was thought proper to tie the carotid; this operation was accomplished without difficulty, and served promptly to reduce the swelling and tension of the parts, pulsation being immediately arrested, and the ligature coming away safely three weeks subsequently. Slight sloughing of the cornea occurred, leaving a patch of opacity, and the sight of the eye remained much impaired; but, with these exceptions, the patient when last heard from bore no traces of his disease.

We have not space to follow Mr. Rivington in his discussion of the various pathological conditions which may give rise to the so-called "intra-orbital aneurism," further than to quote his opinion that of recorded instances nearly all the traumatic cases have been examples of arterio-venous communication in the cavernous sinus, and that in idiopathic cases the most frequent condition has been the sudden formation or rupture of an aneurism of the internal carotid in the same locality. Mr. Rivington does not believe that the symptoms of "intra-orbital aneurism" are ever due to the existence of an aneurism by anastomosis or a cirsoid aneurism, neither of which has ever been proved by *post-mortem* inspection to have occurred as an affection strictly limited to the orbit. As, however, these conditions do undoubtedly implicate the orbit secondarily, in some cases, we do not see why under such circumstances they should not merit the name of pulsating orbital tumours. The diagnostic mark by which to distinguish such cases from the ordinary forms of "intra-orbital aneurism," would appear to be that in the former the *globe* of the eye is not involved, and that hence exophthalmos and chemosis cannot be present.

The next paper which demands our attention is entitled *A Case of Left Subclavian Aneurism treated by Temporary Compression applied directly to the Artery in the First Part of its Course; with Remarks;* by Arthur Fergusson McGill, F.R.C.S., Surgeon to the Leeds Public Dispensary; communicated by John Wood, F.R.S. Mr. McGill's patient was a woman, 35 years of age, and at the time of the operation had been suffering from aneurism of the left subclavian artery for nearly three years. Digital compression had been previously applied to the *third* portion of the artery without benefit, and galvano-puncture had been employed upon five occasions with temporary advantage, but without effecting a permanent cure. Mr. McGill determined to try direct temporary compression of the *first* portion of the artery (internal to the scaleni muscles), being encouraged as to the feasibility of the operation by the record of the case in which the late Dr. J. K. Rodgers, of New York, had tied the left subclavian in its first part (the only occasion upon which the operation had been previously accomplished), and hoping that by the use of temporary compression, rather than ligation, the risk of secondary hemorrhage would be in a great degree avoided. The operation proved to be one of great difficulty, the artery being displaced from its normal position, and in passing a Gibson's needle around the vessel the pleura was unavoidably wounded. Compression was effected by applying a pair of ordinary torsion forceps, which were allowed to remain a little more than six hours. The pulsation, which was absent when the compressor was removed, returned in a slight degree on the next day, but finally disappeared on the day following. The patient died (from pleurisy) on the sixth day, *post-mortem* examination showing that the aneurismal sac was entirely filled with a firm hard clot, and that the artery was quite healthy at the point of compression.

The last surgical paper is *On the so-called Partial Dislocation of the Humerus*, by EDMUND OWEN, F.R.C.S., Assistant Surgeon to, and Demonstrator of Anatomy at St. Mary's Hospital; communicated by GEORGE GREEN GASCOYEN, F.R.C.S. In this paper Mr. Owen describes four dissecting-room specimens which he has himself observed (the right and left shoulder-joints of two subjects), and compares them with the specimens described by Sir Astley Cooper and Mr. Soden, concluding that the affection described by the former writer as partial dislocation of the humerus, and by the latter as dislocation of the tendon of the long head of the biceps muscle, is in reality a lesion of rheumatic origin and not the result of injury. This view, it may be mentioned, is by no means a novel one, having been ably sustained more than twenty years ago by Mr. E. Canton (*Surgical and Pathological Observations*, London, 1855, pp. 18–28), and still earlier by Dr. R. Adams, of Dublin. As Mr. Canton's name is not even mentioned by Mr. Owen, it is a fair inference that the latter is not acquainted with the former writer's investigations.

As far as the surgical portion of this volume is concerned, we cannot consider it either as interesting or as valuable as some of its predecessors.

J. A., JR.

Two of the medical papers in the volume have been fully noticed in *The Monthly Abstract of Medical Science*. Having, therefore, been already laid before most of the readers of the Journal, we shall only mention them by name. The first is contributed by Dr. GEORGE JOHNSON, who has written *On the Laryngeal Symptoms which Result from the Pressure of Aneurismal and other Tumours upon the Vagus and Recurrent Nerves*. The second is by Dr. GEORGE THIN, and contains the results of his investigations into *The Pathology of Lupus Erythematosus*.

Dr. LEONARD H. J. HAYNE communicates some *Notes on an Epidemic of Malarious Yellow Fever occurring on board H. M. S. Doris, shortly after leaving Port Royal, Jamaica, May 18th*, 1873. The disease which he describes seems to have been a very severe remittent fever. In one case, indeed, black vomit occurred, but, with this exception, there were no symptoms which could not readily be referred to the former disease. Malarious yellow fever is described by Aitken,[1] who says, that it prevails, for the most part, in towns situated on the sea or river coasts of alluvial countries, in warm climates. "The malarious form of yellow fever," he adds, "appears to be the product of that state of the atmosphere which takes place after a long continuance of solar-heat, with little or no wind, in those points chiefly where the atmosphere of the sea and that of the land are in constant communication and interchange."

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[1] The Science and Practice of Medicine, by Wm. Aitken, M.D., etc., vol. i. p. 538, London, 1866.

Dr. C. Theodore Williams contributes a paper *On the Temperature of Phthisis Pulmonalis, and on the Various Conditions influencing it*, in which he reports his observations made at the Brompton Hospital for Diseases of the Chest. The number of patients furnishing these results was 111; 66 of whom were males, and 45 females. The ages were from 13 to 49; the average of the males being 26, and of the females 27. In the greater number of cases, almost hourly observations were taken, and in eleven cases, an hourly record was carried out for twenty-four hours. The patients under observation were, for the sake of convenience, arranged in five classes, according to the stage of the disease and the activity of its progress: 1st stage, *active;* 1st stage, *quiescent;* 2d stage; 3d stage, *active;* 3d stage, *quiescent.* In the first class, the observations taken at 8 A. M. exhibit remarkably low temperatures; 51 per cent. being below 98°. They show a slight exacerbation at 10 A. M., and a consequent fall, and then a nearly continuous or slight rise from 2 P.M. till 8 o'clock (over 100°), when a rapid fall commences, which reaches its lowest ebb between 2 and 3 A. M. Temperatures of 94° and 95° were then not unfrequently recorded. In the second class the 8 A. M. observations indicated subnormal temperatures, the mean being 97.3°, the minimum 95.2°, and the maximum 98.5°. At 11 o'clock the temperatures were still low, the average being 97.9°. The observations at 2 P. M., showed a steady rise, which reaches its maximum at 5, an average of 98.7° being then attained.

In the third class the temperatures at 8 A. M. were somewhat higher than in the first and second classes; the mean being 98.1°, and the minimum 95.6° At 11 o'clock a rise generally takes place, the mean being 99.1°, the minimum 96.8°. After this a steady rise generally takes place till 8 P. M., the mean being 99.6°, and the highest temperature recorded being 103.6°. The thermometry of the "active third stage" shows greater extremes than that of any other, and includes both the highest and lowest temperatures, the actual maximum being 104.6°, which may be arrived at any hour between 5 and 10 P.M., and the minimum being 93.6°, which is generally observed at about 2 A. M. In the fifth class, of the 8 A. M. temperatures 60 per cent. fall below 98°, the minimum being 95°, the mean 97.7°. The 11 A. M. indicate a slight rise, the mean being 98.2°. At 5 P. M., the maximum is reached, the mean being 98.6°. The 11 P. M. notes indicate a slight subsidence.

Dr. Williams calls attention to two main facts which appear to be established by his observations: 1st. The post-meridian character of pyrexia, when pyrexia exists at all. 2d. The remarkable fall at night and the subnormal temperature of the early morning. The pyrexia he attributes to "an excessive action of the natural processes by which the body heat is maintained." The fall in the night, he thinks, is due to "the influence of collapse proceeding from the well-marked weakening of the constitutional powers in phthisis." The following are the deductions which the author draws from a series of observations in reference to the loss of weight in the various stages of phthisis: 1st. That, though the tendency of the disease is towards emaciation, gain of weight is possible in every stage, provided there be no diarrhœa or hæmoptysis, and that food can be taken and assimilated. 2d. That pyrexia is not incompatible with gain of weight, provided the appetite be good. 3d. That, while active third stage cases are the least likely to gain weight, chronic cavity patients are the most likely to increase in flesh. 4th. That neither tuberculization nor softening precludes gain of weight.

Dr. WILLIAM MARCET's article, entitled *Contributions to the History of Laryngeal Phthisis*, is founded upon 70 cases of the disease which came under his observation at the Brompton Hospital for Consumption. After a brief notice of the literature of the disease, the author proceeds to analyze his cases with the following result: Of the 70 patients, 49 were males, and 21 females. Flint, in his new work on Phthisis,[1] records even a greater proportionate frequency of the disease in men than this; for of 61 cases observed by him, only 4 occurred in women. There is, therefore, fair ground for concluding that men are more liable to the disease than women. Of 55 cases in which the ages were recorded, 26 were of patients between 20 and 30 years of age. This seems to show that age has little or no influence as a predisposing cause of laryngeal phthisis, as a large preponderance of cases of phthisis occurs between these ages. In a given number of cases of consumption, the larynx, Dr. Marcet believes, will be attacked much more frequently among those who seek relief at hospitals, and in them the disease will run a more severe course.

The author could not trace the laryngeal affection to overwork of the vocal organ, and, to his surprise, there was not a single hawker among his patients. He is inclined to attach more importance to deficient exercise, want of pure air, and the neglect of hygiene as causes of laryngeal phthisis. Although Dr. Marcet does not attribute any positively contagious properties to the breath in laryngitis or phthisis, he thinks it not improbable that the tendency to consumption resulting from a sedentary occupation in crowded and ill-ventilated rooms is partly owing to the irritating influence of expired air. He finds that irritation of the larynx is very readily set up in his own person by inhaling the breath of the person whom he is examining with the laryngoscope.

Aphonia may occur during the course of consumption, without there being any inflammation or tubercular growth in the vocal organ. The patient finds out that after speaking for a length of time the voice drops, or it fails; while singing, reading aloud, or teaching has to be discontinued, and the act of phonation becomes an effort. In most of these cases the laryngoscope will show that the tension of the cords is at fault; in a few cases adduction is seen to be incomplete. This condition he attributes to the deficient state of nutrition of the lungs, which weakens the functions of the laryngeal nerves by a reflex action through the inferior ganglion of the pneumogastric. Electricity in these cases is of little service, but on the other hand an improvement in the state of the lungs and in the general health will often be attended with a simultaneous favourable change in that of the voice.

The lesions of laryngeal phthisis, which the author describes, are so well known that it is not necessary to recount them here. The epiglottis was observed to be affected in 31 out of the 70 cases, the change consisting in a hardening and alteration in shape, which caused it to present a shrivelled-up and contracted appearance. The pain felt in the throat in these cases is sometimes excruciating, especially during the act of deglutition. The prognosis is, as a rule, unfavourable. "The ultimate or late form is the last blow given to a constitution shattered by pulmonary disease." This is a very different opinion from that given by Dr. Flint in the work already referred to. The treatment which Dr. Marcet recommends is the introduction into the larynx of a few drops of the following solution: Iodine, gr. x–xx; iodide of potassium, gr. ij–iij; olive oil, f℥j. In case of much irritation of the larynx, this solution may be diluted with an equal bulk of olive oil. The same solution may be rubbed into the skin in the front part of the neck; the object being not to produce counter-irritation, but to obtain an absorption of the iodine. When the soft parts of the larynx are much swollen and hardened, scarifying the parts with Mackenzie's laryngeal scarifier sometimes gives relief. The author has discarded the use of solutions of nitrate of silver, perchloride of iron, or of any strongly astringent or irritating fluid. Solutions of bromide of potassium and alum in glycerine are better. He has frequently found benefit to follow the removal of patients from low to high situations.

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[1] Phthisis; its Morbid Anatomy, Etiology, Symptomatic Events, and Complications, etc. Philadelphia: Henry C. Lea, 1875.

We shall give, in his own words, the most important of the conclusions which Mr. Samuel West draws from his *Observations upon the Eliminations of Urea in Certain Diseases*. And first, in regard to the percentage of urea. I. During the fever the percentage is high, and remains fairly constant as long as the fever lasts. II. During the fever it does not follow the slight variations of temperature. III. Changes in diet cause, during the fever, the same oscillations as they cause during convalescence. IV. The first period of convalescence is characterized by a gradual and progressive fall in the percentage, even until it is considerably below the normal. V. The second period is characterized by a gradual and progressive rise in the percentage, until at last a mean varying from 1.5 to 2.0 is established, when it becomes constant. The following are his conclusions as to the total amount of urea: *During the fever.* I. The total amount is much reduced, and is not in large excess (as stated commonly in the books). II. The total amount varies very considerably from day to day, independently of any law which we can determine at present. III. These variations are independent of the diet. IV. And also of the temperature; hence the total urea is not a measure of fever. V. The variations depend upon the total volume of the urine rather than upon the percentage of urea. VI. The variation was considerable in the different cases quoted. *During the convalescence.* VII. The whole amount is often extremely reduced. VIII. It gives an average which is different in the two periods of convalescence, but sometimes that of the first period is higher and sometimes lower than that of the second period. This may be accounted for, perhaps, by the different fevers, from which convalescence is taking place. IX. The same variations, independent in a great measure of the diet and of the percentage, and varying with the total volume of the urine, are to be noticed during convalescence or during fever.

With the statements that urea is the measure of tissue change, and also that its excretion is governed by the same laws in health and in disease, the results of Dr. West's observations seem hardly to agree; for it has been pointed out that the relation between the amount of nitrogen in the food and that estimated in the urine as urea is by no means so close as it is asserted to be in health.

Dr. J. Wickham Legg is the author of a paper *On the Histology of the So-called Nutmeg Liver*, which is based upon microscopic examination of twenty livers which showed a well-marked nutmeg appearance. In the earlier stage of the disease, the chief morbid appearance is to be found in the centre of the acinus, and is caused by the dilatation of the radicles of the hepatic vein. In the section these vessels may be seen distinctly enlarged and still completely filled with red corpuscles. The liver-cells themselves seem to be at first not much changed in character. Their outline is, however, hard to be made out, so that they cannot readily be counted; they show a large nucleus and granular contents. In the later stages the dilatation of the capillaries becomes very great, and in this way grave changes are wrought upon the tissues immediately around them. The rows of liver-cells between the vessels are so much pressed upon that their shape becomes almost linear. The latest stage of all is that in which the centre of the lobule becomes little more than a network of vascular tissue, between the meshes of which a few highly granular and pigmented liver-cells lie. On looking at specimens in this stage with a low power, the outer part of the acinus is seen to be formed of a ring of almost colourless liver-cells, while the centre is filled with a red tissue, studded with pigmented liver-cells; and this tissue, as seen with a low power, looks very like connective tissue, But on examining the specimen with higher powers, it is found to be made up of channels, the walls of which are exceedingly delicate and transparent, and within which red-blood corpuscles can still be made out. No nuclei are seen in the midst of this tissue as in the interlobular tissue, but studding the field are numerous rounded or slightly polygonal cells, with highly pigmented contents, and containing no discoverable nucleus. These cells Dr. Legg holds to be the remains of liver-cells. The tissue in the centre of the lobule was regarded by Rokitansky as an overgrowth of connective tissue, but the author is quite unable to agree with this statement. He has also not found fatty infiltration of the cells of the outer border of the lobules quite so frequently as is stated by writers to be the case.

In the earlier stages the capsule of Glisson may be found increased in size and with numerous lymphoid corpuscles present in it. When the latter are present, they are most abundant in the sheath of the vessels; and it is around the interlobular vessels that the increase of the connective tissue is most marked. In the later stages the increase of connective tissue becomes far more marked, and the lymphoid bodies are never absent throughout the whole of the liver. The connective tissue is strewn with them just as in primary cirrhosis. The connective tissue is not always developed to the same degree in every part of the same liver, and in the specimens Dr. Legg examined, was never so much increased as to penetrate within the lobules themselves. He doubts whether the growth of the interlobular tissue ever becomes so great as to give a hobnailed appearance to the liver.

The author thinks it unwise to call this form of liver-disease red atrophy, as has been done by Rindfleisch, since this name was given by Virchow to a rare state of the liver met with after wasting diseases, such as typhoid fever.

We can only notice by title Dr. ALFRED L. GALLABIN's article *On the Construction and Use of a New Form of Cardiograph*, as the description of the instrument would occupy more space than we feel justified in devoting to the subject.

Dr. ROBERT McDONNELL's report *On a Case of Double Facial Palsy, with Observations on the Physiology of the Nerves supplying the forepart of the Tongue*, will be found to be interesting. The patient, a healthy man, 24 years old, attributed his paralysis to exposure to wet and cold. With the facial palsy there was loss of the sense of taste in the anterior portion of the tongue, which was of course due to the fact that the *chorda tympani* was involved in the paralysis. There was no loss of general sensibility in the organ, the patient being able to detect the slightest touch, and to distinguish the double points of the æsthesiometer with the lip of his tongue as well as the experimenter or his students. Two egg cups being filled with water slightly differing in temperature, the patient could perceive without hesitation or mistake, a difference not amounting to more than four or five degrees. But he could not detect any difference between solutions of sugar, citric acid, salt and quinia, when these were applied by means of camel's hair brush to the fore part of the protruded tongue, until he was allowed to withdraw his tongue into his mouth. The secretion of saliva excited by the application of sapid substances to the forepart of the tongue was in abeyance. The functions of all the other cerebral nerves was unimpaired. The author at the close of his paper refers to a case reported by Dr. Althaus, in the 52d volume of these Transactions,[1] in which there was complete loss of function of the whole fifth pair of cerebral nerves unaccompanied by any other affection of cerebral or nervous matter. The two cases may be regarded as completely complementary to each other. J. H. H.

Art. XXVII.—*Transactions of the American Ophthalmological Society.* Eleventh Annual Meeting. 8vo. pp. 359. New York: William Wood & Co., 1876.

This volume bears ample evidence of the activity of the American Opthalmological Society, and worthily supports the reputation established by its predecessors in the series. In accordance with our custom, we shall analyze its contents.

The first paper is by Dr. O. D. Pomeroy, of New York, and is a report of *A Case of Nystagmus, associated with Concomitant Convergent Strabismus in Emmetropic Eyes, relieved by correction of the Squint.* The squint had existed since infancy, and there was diminished vision, with ophthalmoscopic signs of old choroiditis. It was almost impossible to obtain even a cursory view of the fundus oculi, so constant and rapid were the oscillatory movements of the eyes.

After tenotomy of the internal rectus, performed twice on one eye and once on the other, the squint was completely corrected and the nystagmus disappeared. The results of the operations remained unimpaired at the end of two years.

A Case of Spontaneous Cure of Sub-retinal Effusion, with an Analysis of Twenty-one Cases of the same Disease, is the title of a paper contributed by Dr. David Webster, of New York. The patient was a lady 57 years of age. She had always been excessively near-sighted, but had never worn glasses, and her eyes had never given her much trouble until the summer of 1874. She had then been confined to bed for a few days with "a rush of blood to the head," and her vision had been somewhat impaired. In about a year it became suddenly worse.

When seen by Dr. W. vision was much diminished in both eyes and confined entirely to the lower portions of the visual fields. Ophthalmoscopic examination showed a detachment of the lower half of the right retina. The vitreous was opaque in the left eye. The patient was kept on her back in bed for ten days, the eyes being constantly under the effect of atropia. At the end of that time, the detached retina had resumed its natural position, and the vision was much improved.

Dr. Wadsworth reported a case in which the separated retina was replaced spontaneously; Dr. Mathewson, one in which recovery took place after repeated application of dry cups to the temple; Dr. Strawbridge, one in which the retina was replaced by rupturing it with needles, and Dr. E. Williams, one in which the same result followed its rupture by accidental injury.

Under the head of *Rare Cases, with Practical Remarks,* Dr. E. Williams, of Cincinnati, reports the following cases:—

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[1] See Amer. Journ. of Med. Sci., vol. lix.